CONNECTICUT CENTER FOR ORTHOPEDIC SURGERY, LLC

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Name ____

Date ____

KNEE SURVEY

Knee evaluated   Right   Left   Both
Is this work related?   ❒ Yes   ❒ No

What is the problem with your knee?
____
____

Is the problem getting   ❒ worse   ❒ better   ❒ staying the same?
Is this related to an injury?   ❒Yes ❒No
If yes, describe how it happened.
____
____

Which word best describes your pain?   ❒ None   ❒ Mild   ❒ Moderate   ❒ Severe

Select one statement below regarding your knee pain.
❒ **Normal function**: I can do all activities of daily living, work and sports activities that I did before my knee problem.
❒ I have **mild limitations** in sports and work and activities of daily living.
❒ I have **moderate limitations** in activities of daily living. No sports possible.
❒ I have **severe limitations**. Cannot do usual work or lifting. No sports.
❒ **Complete disability** of he knee.

Where is the pain?   ❒Inner side   ❒Front of knee cap   ❒Outer side   ❒Back of knee   ❒All over

How often do you get pain?   ❒Never ❒Monthly ❒Weekly ❒Daily ❒Always

How bad is you pain today?   No pain> *0 1 2 3 4 5 6 7 8 9 10* <Worst pain imaginable

Describe the pain   ❒Constant   ❒Comes and goes
❒Dull   ❒Sharp   ❒Throbbing   ❒Burning   ❒Aching

Do your knee   ❒Pop   ❒Click   ❒Catch / locking   ❒Give way (knee collapses or buckles)   ❒Swell
❒Grind

Check all that apply   ❒Knee stiffness in the morning
❒Knee stiffness later in the day
❒Stiffness after sitting, lying or resting

Have you had previous x-rays or MRI s of the shoulder?

When ____________________

Where ____________________

Have you had previous treatment for this condition? ❐ Yes ❐ No

When ____________________

Who ____________________

❐ Physical therapy ❐ Medication ❐ Injections ❐ Other

Have you had previous surgery for this condition?

When ____________________

Who ____________________

What kind of surgery ____________________